Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PETER G FOOX
PO BOX 8795
TYLER TEXAS 75711

Respondent Name
TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative
Box Number 54

MFDR Tracking Number
M4-13-3146-01

MFDR Date Received
July 26, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: The requestor did not submit a position summary with the DWC060 request.

Amount in Dispute: $140.54

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For date 3/13/13 the requestor billed 1 unit of 97032, 2 units of 97110, 1 unit of 97112, and 1 unit of 97140. Applying the DWC MAR to the number of units billed you get $29.40 for code 97032, $99.08 for the 2 units of 97110, and etc. Texas Mutual correctly paid the fee schedule amount for both the 3/13/13 and 3/15/13 dates. The requestor billed code 99212-25 for an E/M service on the same date as the physical medicine treatment of 3/13/13. The use of the '25' modifier requires a significantly separate E/M service apart from the physical medicine treatment of the same date. However, Texas Mutual argues the E/M documentation does not support that. As such no payment was made."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 13, 2013	99212-25, 97110-GP, 97112-GP, 97032-GP and 97140-GP	$140.54	$67.16

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the medical fee guideline for professional medical services.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 150 – Payer deems the information submitted does not support this level of service
   - 864 – E/M service may be reported only if the patient's condition requires a significant separately identifiable E/M
   - W1 – Workers Compensations tae fee schedule adjustment
   - 725 – Approved non network provider for Texas Star Network claimant per rule 1305.153 (C)
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 724 – No additional payment after a reconsideration of services.
   - 857 – Modifier -25 billed. Documentation does not support a significant separately identifiable E&M service

Issues

1. Did the requestor submit documentation to support the billing of CPT code 99212-25?
2. Did the insurance carrier issue payment to the requestor according to the fee guidelines for the physical therapy codes?
3. Is the requestor entitled to additional reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   In order to determine proper reimbursement, NCCI edits were run to identify if edit conflicts would affect the billing of CPT code 99212-25 with the physical therapy codes billed on the same day. No edit conflicts were identified.

   The requestor disputes non-payment of CPT code 99212-25. The CPT code descriptor for 99212 is "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family." The requestor appended modifier -25 which is defined as "Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service." Review of the submitted documentation titled *BRIEF OFFICE VISIT* documents two of the three key components, therefore the requester is entitled to reimbursement for CPT code 99212 in the amount of $67.16.
2. Per 28 Texas Administrative Code §134.203 "(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor disputes non-payment of CPT codes 97110-GP, 97112-GP, 97032-GP and 97140-GP.

   Review of the CMS MLN matters # MM7050 states in pertinent part, "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings. The reduction applies to the HCPCS codes contained on the list of "always therapy" services that are paid under the MPFS, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, Home Health Agencies (HHAs), and Comprehensive Outpatient Rehabilitation

Facilities (CORFs), etc.). The MPPR applies to the codes on the list of procedures included with CR7050 as Attachment 1. CR7050 is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R826OTN.pdf on the CMS website. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example based on the 75 percent reduction for institutional settings."

The disputed physical therapy codes; 97110-GP, 97112-GP, 97032-GP and 97140-GP are identified on the “List of Therapy Procedures Subject to the Multiple Procedure Payment Reduction” therefore subject to the Multiple Procedure Payment Reduction (MPPR). Reimbursement is calculated according to the MPPR.

3. Per 28 Texas Administrative Code §134.203 "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32. (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

Per CMS the Procedure code 97110, service date March 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.912 is 0.43776. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.89585 is multiplied by the Division conversion factor of $55.30 for a MAR of $49.54. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $44.70 at 2 units is $89.40. The insurance carrier paid $99.08, therefore no additional payment is recommended for CPT code 97110.

Procedure code 97112, service date March 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.45. The practice expense (PE) RVU of 0.52 multiplied by the PE GPCI of 0.912 is 0.47424. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.93233 is multiplied by the Division conversion factor of $55.30 for a MAR of $51.56. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $51.56. The insurance carrier paid $51.56, therefore no additional payment is recommended for CPT code 97110.

Procedure code 97032, service date March 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.25 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.25. The practice expense (PE) RVU of 0.3 multiplied by the PE GPCI of 0.912 is 0.2736. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.53169 is multiplied by the Division conversion factor of $55.30 for a MAR of $29.40. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $26.38. The insurance carrier paid $29.40, therefore no additional payment is recommended for CPT code 97032.

Procedure code 97140, service date March 13, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.912 is 0.40128. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.809 is 0.00809. The sum of 0.83937 is multiplied by the Division conversion factor of $55.30 for a MAR of $46.42. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is $41.98. The insurance carrier paid $46.42, therefore no additional payment is recommended for CPT code 97032.

4. Review of the submitted documentation finds that the requestor is entitled to additional reimbursement in the amount of $67.16.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $67.16.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $67.16 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	September 26, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.